NOTICE OF INDEPENDENT REVIEW DECISION

February 5, 2003

RE: MDR Tracking #: M2-03-0526-01
IRO Certificate #: IRO 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in orthopedic surgery which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 37 year old male sustained a work-related injury on ___ when he fell from an oil rig injuring his low back and neck. The patient complains of headaches, neck and low back pain. An MRI of the lumbar spine performed on 05/07/02 revealed early disc desiccation with a 1-2mm posterior annular bulge at L4-5. An MRI of the cervical spine revealed evidence of cervical intervertebral disc disease. The patient has been treated with spinal manipulation, physical therapy, pain medications and epidural steroid injections. The treating physician has recommended that the patient undergo a myelogram/CT scan and a discogram/CT scan.

Requested Service(s)

Myelogram/CT scan and a discogram/CT scan.

Decision

It is determined that a discogram/CT scan is medically necessary to treat this patient's condition. However, it is determined that a myelogram/CT scan is not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The patient has had extensive non-operative management including medication, epidural steroid injections and exercises without resolution of symptomatology. An electromyography indicated evidence of mild right L-5 radiculopathy with no evidence of neuropathy. The medical record documentation states that "The patient has MRI evidence of lumbar intervertebral disc disease. Clinically the patient has lumbar radicular complaints including weakness, numbness and tingling in the lower extremities."

The medical record documentation indicates that the patient does have persistent back pain with leg radiation consistent with lumbar radiculopathy. The treating physician reviewed the MRI and he states that it shows "early disc desiccation with 1-2 mm posterior annular bulge at L4-5." He does not relate any spinal stenosis on his MRI report.

A discogram with post-discogram CT scan is medically necessary. The CT scan at each level will help evaluate for possible spinal stenosis without the need for a myelogram. A provocative discogram can indicate whether or not the patient has significant provocative and reproducible pain provocation in the lumbar spine. Therefore, a myelogram with post-myelogram CT scan is not medically indicated.

Discograms are well accepted by the American Academy of Orthopedic surgeons and the North American Spine Society as a valid test when properly performed. The are multiple opposing papers in the literature indicating both efficacy and non-efficacy of this test. However, this test is well accepted by many spinal surgeons and is considered an acceptable diagnostic tool for discogenic back pain.

Therefore, while the discogram/CT scan is medically necessary to treat this patient's condition, the myelogram/CT scan is not medically necessary to treat this patient's condition

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

cc: Rosalinda Lopez, Program Administrator, Medical Review Division, TWCC

In accordance with Commission Rule 102.4 (h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 5th day of February 2003.